TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elevate Physical Therapy

Respondent Name
Hartford Fire Insurance

MFDR Tracking Number
M4-17-2658-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please find attached DWC-060 form and HCFAs for below patient's claims. Earlier Hartford insurance denied claims as untimely however, claims were submitted timely."

Amount in Dispute: $579.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found the following: Original billing and subsequent billing received 6/15/2016, 10/11/16 & 11/17/16 were returned to the provider with letters requesting appropriate modifiers for physical therapy codes (Rule 133.200). Corrected billing received 02/20/17. Dates of service 04/27/16, 05/04/16, 05/07/16, 05/11/16 denied for timely filing (Rule 133.20). Dates of service 05/13/16 and 05/18/16 were inadvertently paid on 03/20/17."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2016 through May 18, 2016	97110, 68979, G8980	$579.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - 246 – This non-payable code is for required reporting only
   - 4278 – This non-payable G code billed with or without an appropriate modifier is for reporting purposes only

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service April 27, 2016 and May 4, 2016?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?
4. Is the requestor due additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   Regarding dates of the services in dispute April 27, 2016 and May 4, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 9, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service April 27, 2016 and May 4, 2016.

2. The insurance carrier denied disputed service for May 11, 2016 with claim adjustment reason codes: 29 – "The time limit for filing has expired" and 937 – "Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service."

   The requestor states in their position statement in pertinent part, "…claims were submitted timely." A review of the submitted documentation finds the carrier notified the requestor on November 17, 2016 that claims were being returned with the following message, "Please resubmit bill with appropriate modifiers for physical therapy codes."

   28 Texas Administrative Code §133.20 (g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

   Included with the documentation presented with the request for Medical Fee Dispute Resolution were claims containing the requested modifiers that contained a signature date of January 23, 2017. However, this corrected claim was considered a new bill and the timely filing requirement detailed below was not from the date the claim was corrected and returned but rather 95 days from the date of service as required by 28 Texas Administrative Code §133.20(b) which requires that, except as provided in Texas Labor Code

§408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Texas Labor Code §408.0272(b) provides that:

> Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
>
> (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
>
> (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
>
> (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
>
> (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
>
> (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute.

For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided and the requestor's position that the "claims were submitted timely," is not supported.

3. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

> Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
>
> (1) the date received, if sent by fax, personal delivery or electronic transmission or,
>
> (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for date of service May 11, 2016, pursuant to Texas Labor Code §408.027(a).

4. Regarding the services in dispute for dates of service May 13, 2016 and May 18, 2016. The carrier reduced the amount paid with remark codes, 119 – "Benefit maximum for this time period or occurrence has been reached" and 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules.

28 Texas Administrative Code §134.203 (b) states in pertinent part,

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, Publication 100-4, Chapter 5, Section 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states in pertinent part,

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

Based on the above, the carrier's reduction code of 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules" is supported. The maximum allowable reimbursement calculation is found below.

28 Texas Administrative Code 134.203 (c) states in pertinent part,

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)

The maximum allowable reimbursement is calculated as follows;

- Procedure code 97110, service date May 13, 2016, has a MAR of $49.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. The first unit is paid at $49.50. The PE reduced rate is $38.00 at 3 units is $114.00. The total is $163.50.
- Procedure code 97110, service date May 18, 2016, has a MAR of $49.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. The first unit is paid at $49.50. The PE reduced rate is $38.00 at 3 units is $114.00. The total is $163.50.
- Procedure code G8979, service date May 18, 2016, denotes a therapy functional information code (used for required reporting purposes only). No reimbursement is due.
- Procedure code G8980, service date May 18, 2016, denotes a therapy functional information code (used for required reporting purposes only). No reimbursement is due.

The total allowable reimbursement for the services in dispute is $327.00. This amount less the amount previously paid by the insurance carrier of $327.06 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 26, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.